PRINTED: 06/08/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
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		17E630	B. WIN	IG		06/0	7/2012
	ROVIDER OR SUPPLIER Y COMMUNITY CARE CE	:NTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 12 N 5TH AVE INTHONY, KS 67003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
F 280 SS=D	complaint investigation 483.20(d)(3), 483.10(F	280			
	incompetent or other incapacitated under the	he laws of the State, to g care and treatment or					
	within 7 days after the comprehensive assess interdisciplinary team physician, a registere for the resident, and of disciplines as determ and, to the extent prathe resident, the resident legal representative;	re plan must be developed be completion of the sesment; prepared by an and that includes the attending and nurse with responsibility other appropriate staff in sined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed an of qualified persons after					
	by: The facility census to sampled. Based on or record review the facine revision of the care place.	is not met as evidenced otaled 32 residents, with 3 observation, interview and ility failed to ensure the lan related to additional ent accidents for 2 of 3 1 and #3).					
	Findings included:						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E630	B. WIN				C 7/2012
	OVIDER OR SUPPLIER	NTER	•	212	ET ADDRESS, CITY, STATE, ZIP CODE 2 N 5TH AVE ITHONY, KS 67003	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	Set) dated 8-15-11 id BIMS (Brief Interview which indicated sever resident's cognitive state depressed and bad a identified no behavior weeks previous to the The MDS identified the supervision of one state living (ADL's) with the room for which the reassistance. The MDS not steady but able to from a seated to stan and moving on and oridentified the resident five days previous to MDS identified no fall. The quarterly MDS day resident with a BIMS impaired. The MDS influctuating periods of MDS also identified the to 6 days of the look 10 previous to completion collection), but not day resident with wandering the look back period. The MDS indicated the look back period. The MDS showed the help for bathing. The was not steady, but a	ission MDS (Minimum Data entified the resident with a of Mental Status) of 6, re impairment of the ratus, feeling down or bout him/herself. The MDS ral symptoms over the two re completion of the MDS. The resident required raff for all activities of daily reexception of walking in the resident required no redentified the resident was restabilize self when moving ding position, turning around for the toilet. The MDS rahad pain, but not within the completion of the MDS. The for the resident. The resident with delusions 4 pehind period (the 7 days	F	280			

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F 280	standing position and on and off the toilet. resident with the presprevious 5 days. The had not had any falls. The CAA (Care Area 8-15-11, identified the falls related to balance postural hypotension, dementia, signs and a history of impulsivity awareness. Review of the care pleacked any intervention wanderguard to alert building. Administration of such on 6-5-12 at review also revealed intervention indicating supervision while on also confirmed the laccare plan that would be resident while on the Review of nursing not a.m. noted a late entrenoted the resident had behaviors" and had rehe/she had gone to the evening and someone the cops were after hone of the sident had the cops were after hone of the tops were after hone.	turning around and moving The MDS identified the ence of pain, but not in the eMDS showed the resident Assessment) for falls, dated e resident with a potential for e problems, medications, anemia, cognitive loss, symptoms of depression and y and poor safety an last reviewed on 2-12-12 on related to the use of a staff if the resident left the ye Staff E confirmed the lack 1:25 p.m. The care plan the lack of any care plan the lack of any care plan g the resident required the outdoor patio. Staff E ck of an intervention on the require staff to supervise the outdoor patio. tes dated 4-10-12 at 10:00 y for 4-7-12. The entry d some "abnormal epeated over and over that he store the previous e stole his/her car and now	F	280			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUI COMPLET	
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F 280	On 4-18-12 at 1:00 president was in anoth refused to move. The was confused and se feeling staff had calle him/her for hurting so A nursing note on 4-2 resident had increase the roommates things and then angered resindicated the resident and had delusions an someone he/she did room. The note also wandered about the f support from staff. A nursing note dated documented the residesk at 10:40 a.m. an reported he/she was to jump the fence to get thought he/she broke The nurse assessed is sent the resident to the hospital. The not returned to the facility reported to the staff the in his/her right wrist. Interview on 6-5-12 a staff A revealed resid go onto the patio when A said resident #3 did onto the patio with hir checked on the resident with the resident on the resident was a staff A revealed resid go onto the patio with hir checked on the resident was a staff A revealed resident was a staff A revealed resident to the patio with hir checked on the resident was a staff A revealed resident was a staff A reve	er resident's room and enurse noted the resident emed distrusting of the staff, dhim/her a liar and blamed meone. 25-12 at 1:45 p.m. noted the ed behaviors, had gotten into s, which upset the roommate ident #3. This same note had headaches recently dhallucinations and felt not know was in his/her stated the resident acility more and looked for 5-1-12 at 4:00 p.m. Hent went to the nursing and was crying. The resident on the back patio and tried get to music lessons and his/her arm and shoulder. The resident's injuries and the emergency department at the continued that the resident	F	280			

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F 280	looked out on the patito the direct care staff al was out on the patio, assigned to supervise plans for the direct caback of the door to eastaff A said he/she we changes to resident # on the patio. Interview with direct op.m. revealed resident sometimes said thing said he/she was in the when resident #3 can he/she had hurt him/r fence to get to the buthe resident also told was hurt before going on to the nurses desk he/she was hurt. Interview with License p.m. revealed he/she resident #3 for safety was having more delurestless. Staff D express having more delurestless. Staff D express a highway so clothallucinations/delusion resident #3. Review of resident	when they went by to go kitchen area. Staff A said so told each other someone however no staff were the patio. Staff A said care re staff were kept on the ach resident's bathroom. as not aware of any 3's care after the accident are staff B on 6-5-12 at 3:00 at #3 was "just out there" and so that were not true. Staff B area of the patio door not in on 5-11-12 and said aresident's visitor he/she and telling Licensed Staff D and telling Licensed Staff D and telling Licensed Staff D areasons because he/she usions and was more ressed concern that there se to the facility.	F	280			

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F 280	cognitive impairment resident had inattent changes in severity. disorganized thinking severity of the disorgidentified the resident delusions. The MDS behavioral symptom with resident 's care risk for physical injuring resident required extensive at MDS identified the reand the inability to stassistance for moving position, walking, turn off the toilet and sund The MDS identified to incontinent of urine. The identified to incontine the inability to stassistance and incontinent of urine. The identified to incontine the incontinent of urine. The identified	Status) of 2, indicating severe to the MDS identified the ion that came and went, with The resident also displayed go, with changes in the granized thinking. The MDS at to have hallucinations and a salso noted the resident had as that significantly interfered and put others at significant y. The MDS identified the rensive assistance of two as (Activities of Daily Living) ersonal hygiene which assistance of one person. The resident with unsteadiness rabilize without human go from a seated to standing aning around, moving on and rece-to-surface transfers. The MDS identified the resident was frequently the MDS identified the resident wild a MDS showed the resident	F 280			

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	COVIDER OR SUPPLIER	122		STREET ADDRESS, CITY, STA 212 N 5TH AVE ANTHONY, KS 67003	•	07/2012
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F 280	for eating. The Cognitive CAA (dated 12-9-11 identification Alzheimer's Dement disturbances, a short with forgetfulness, dipast at times through The Fall CAA dated resident with a history poor balance, unstead crisscrossing steps at cognitive loss and has the facility last revied 3-27-12. Care plant prevention of falls in weight bearing assist provide weight bearing with a gait belt and vassist as sometimes anticipate resident's call light, make frequed on the close the door care plant included: to brakes and initiation when up in the wheelin room alone, check order before leaving 4-25-12 to educate seresident to toilet per attempting to climb of ask if he/she needs mental capacity and void/have stools.	Care Area Assessment) fied the resident had it awith behavioral it attention span, confusion isorientation and lived in the in hallucinations and delusion. 12-9-11 identified the ry of falls, poor coordination, ady gait, awkward at times, incontinent, allucinations/delusions. wed the care plan on interventions related to cluded: 1-2 staff to provide trance for transfers, 1-2 staff ing assistance for ambulation valker at times or 2 hand held he/she does better that way, needs, resident does not use tent visual checks for safety, r to room. Additions to the on 4-23-12, lock wheelchair of the use of a body alarm elichair, body alarm on when to to ensure it is in working the room, an addition on staff on mental status, assist	F 2	280		

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F 280	the resident had a ton when in room al in working order be sure non skid socks transfers and ambueach meal. Review of the nursi 4:40 p.m. identified floor between the pnotes identified the 1.5 cm (centimeter) lip and a less than back of forearm, who Review of the care related to this fall. Staff E on 6-6-12 aresident was getting his/her room and the resident was getting his/her room and the resident pedals, any investigation of identification of interfurther falls of this resident stood. The dining room. Two rhave witnessed the the resident stood. The laceration above the the emergency depreceived 7 stitches his/her eye. Review	rses aides noted the following: oileting schedule, body alarm one and check to ensure it is fore leaving the room, make is or shoes are worn for all elation, and walk to dine for any notes dated 4-19-12 at staff found the resident on the edals of the wheelchair. The resident had an approximate alaceration to the right upper and compared to the right of the staff treated at the facility. In plan found no revisions and the received the graph out of the recliner in the wheelchair was next to the ident fell between the staff E confirmed the lack of facuse of the fall and reventions to try and prevent	F 2	80		

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F 280	prevent further falls of Administrative Staff Erevealed the resident at the table alone. Staff the resident at the resident at the resident at the closer and could superclosely. Nursing notes on 5-29 the housekeeper healiving room and summ Staff found the resident The alarm was sound the front right wheel of his/her room and the wheelchair. The residents/her left shoulder at emergency department to treatment. Interviet on 6-6-12 at 10:38 and brought the resident to breakfast and he/she wheelchair. Staff Es woke the resident eart to the living room waiting he/she had instructed resident and bring hir after the resident woke get up and fall. Staff not revised the care profithe 6-6-12 interview. Interview with Adminit 10:53 a.m. revealed investigations did not	f this nature. Interview with and on the living room to wait for attempted to get out of the aid the direct care staff rly and brought the resident sitting in g for breakfast. Staff E said I staff not to wake the more the staff that on the living room to wait for attempted to get out of the aid the direct care staff rly and brought the resident was under the dent complained of pain to and was sent to the more allowed the staff had to the living room to wait for attempted to get out of the aid the direct care staff rly and brought the resident left the resident sitting in g for breakfast. Staff E said I staff not to wake the more out to dining room to etc., so he/she would not try to E confirmed the staff had olan with this intervention as w.	F	280			

NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER CAJ ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG F 280 Continued From page 9 prevent similar falls. Prevailed Direct Care Staff I and Direct Care Staff I assisted the resident with tolieting then walked the resident to the dining room. The direct care staff sat the resident at a table across from the bar. No one else sat at the table. Interview with Administrative Staff E on 6-6-12 at 12:00 p.m. confirmed the staff were to sit the resident at the bar for closer supervision and not at the table away from staff's immediate supervision. Interview with Direct Care Staff H at 10:20 a.m. on 6-5-12 revealed the staff should check on the resident frequently. Staff H said the resident can move really fast and even though staff place a body alarm on him/her, it is usually already going off and the staff cannot get to the resident before he/she falls. Interview with Direct Care Staff J on 6-6-12 at 3:55 p.m. revealed the staff fry to let this resident sleep in later in the morning, because staff think maybe the resident just got tired, fell asleep and fell out of his/her chair. Interview with Administrative Staff E on 6-6-12 at 1 Interview with Administrative Staff E on 6-6-12 at 1 Interview with Administrative Staff E on 6-6-12 at 1 Interview with Administrative Staff E on 6-6-12 at 1 Interview with Administrative Staff E on 6-6-12 at 1 Interview with Administrative Staff E on 6-6-12 at 1 Interview with Admin		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
ANTHONY COMMUNITY CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION WIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) F 280 Continued From page 9 prevent similar falls. Observation on 6-6-12 at 11:52 a.m. revealed Direct Care Staff I assisted the resident to the dining room. The direct care staff staft the resident at a table across from the bar. No one else sat at the table. Interview with Administrative Staff E on 6-0-12 at 10:20 a.m. on 6-5-12 revealed the staff were to sit the resident at the bar for closer supervision and not at the table away from staff's immediate supervision. Interview with Direct Care Staff H at 10:20 a.m. on 6-5-12 revealed the staff should check on the resident frequently. Staff H said the resident can move really fast and even though staff place a body alarm on him/her, it is usually already going off and the staff cannot get to the resident before he/she falls. Interview with Direct Care Staff J on 6-6-12 at 3-55 p.m. revealed the staff tyo let this resident sleep in later in the morning, because staff think maybe the resident just got tired, fell asleep and fell out of his/her chair.			17E630	B. WIN	IG _			
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11:00 a.m. revealed he/she sees the resident trying to do more on his/her own, and staff just need to be educated more about what to do when the resident is more active and what to do when the resident is more sleepy to prevent falls. The facility failed to revise the care plan to reflect additional interventions to prevent further accidents for resident #3. F 323 483.25(h) FREE OF ACCIDENT F 323		prevent similar falls. Observation on 6-6-1. Direct Care Staff H ar assisted the resident the resident to the dir staff sat the resident to bar. No one else sat Administrative Staff E confirmed the staff we bar for closer supervisaway from staff's imm. Interview with Direct on 6-5-12 revealed the resident frequently. Somove really fast and a body alarm on him/he off and the staff cannot he/she falls. Interview with Direct of 3:55 p.m. revealed the staff cannot he/she falls. Interview with Direct of 3:55 p.m. revealed the staff cannot he/she falls. Interview with Adminition 11:00 a.m. revealed in trying to do more on in need to be educated the resident is more at the resident is more at the resident is more at the resident is more accidents for resident.	2 at 11:52 a.m. revealed and Direct Care Staff I with toileting then walked using room. The direct care at a table across from the at the table. Interview with a on 6-6-12 at 12:00 p.m. are to sit the resident at the sion and not at the table sediate supervision. Care Staff H at 10:20 a.m. are staff should check on the staff H said the resident can are though staff place a ser, it is usually already going of get to the resident before Care Staff J on 6-6-12 at a staff try to let this resident corning, because staff think at got tired, fell asleep and r. Strative Staff E on 6-6-12 at the/she sees the resident mis/her own, and staff just more about what to do when active and what to do when active and what to do when alleepy to prevent falls.					

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F 323 SS=G	HAZARDS/SUPER The facility must en environment remair as is possible; and	-	F	323			
	by: The facility census sampled. Based or record review the faprovision of adequadevices to prevent a residents (#1 and # fracture while unsup courtyard area.	totaled 32 residents, with 3 nobservation, interview and scility failed to ensure the te supervision and assistive accidents for 2 of 3 sampled 3). Resident #3 sustained a pervised in an outdoor					
	Set) dated 8-15-11 BIMS (Brief Intervie which indicated sev resident's cognitive depressed and bad identified no behavi weeks previous to t The MDS identified supervision of one s living (ADL's) with the assistance. The MD	mission MDS (Minimum Data identified the resident with a w of Mental Status) of 6, ere impairment of the status, feeling down or about him/herself. The MDS oral symptoms over the two he completion of the MDS. the resident required staff for all activities of daily ne exception of walking in the resident required no DS identified the resident was to stabilize self when moving					

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F 323	from a seated to stan and moving on and or identified the resident five days previous to MDS identified no fall. The quarterly MDS daresident with a BIMS impaired. The MDS ifluctuating periods of MDS also identified the to 6 days of the look to previous to completio collection), but not daresident with wanderithe look back period. resident was indepenfor dressing and pers resident required the The MDS showed the help for bathing. The was not steady, but a human assist when material standing position and on and off the toilet. The total control of the toilet. The CAA (Care Area 8-15-11, identified the falls related to balance postural hypotension, dementia, signs and sa history of impulsivity awareness.	ding position, turning around if the toilet. The MDS had pain, but not within the completion of the MDS. The for the resident. ated 2-2-12 identified the of 4, or severely cognitively dentified the resident with disorganized thinking. The me resident with delusions 4 back period (the 7 days of the MDS data ily. The MDS identified the mg behavior 4 to 6 days of The MDS identified the dent with all ADL's except conal hygiene for which the supervision of one person. The most identified the resident required physical most identified the resident ble to stabilize without moving from a seated to turning around and moving the MDS identified the ence of pain, but not in the most identified the ence of pain, but not in the most identified the resident with a potential for the problems, medications, anemia, cognitive loss, symptoms of depression and	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	IG			C 7/2012
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		772012
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F 323	lacked any intervention wanderguard to alert building. Administration of such on 6-5-12 at a review also revealed intervention indicating supervision while on the also confirmed the lack care plan that would be resident while on the Review of nursing not a.m. noted a late entranted the resident habehaviors" and had rehe/she had gone to the evening and someone the cops were after his	on related to the use of a staff if the resident left the ve Staff E confirmed the lack 1:25 p.m. The care plan the lack of any care plan the resident required the outdoor patio. Staff E ck of an intervention on the require staff to supervise the outdoor patio. The staff to supervise the outdoor patio. The staff to supervise the outdoor patio. The entry dome "abnormal repeated over and over that the store the previous restole his/her car and now rem/her. The nursing notes showed guard on the resident's left The nurse noted the resident remed distrusting of the staff, dome him/her a liar and blamed recone. The staff to supervise the outdoor patio. The entry dome "abnormal repeated over and over that the store the previous resident's left. The nursing notes showed guard on the resident's left. The nurse noted the resident remed distrusting of the staff, domeone. The nurse noted the domeone. The nurse noted the domeone. The nurse noted the domeone.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF _DIN(PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E630	B. WIN	G		06/07	7/ 2012
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F 323	support from staff. The physician's order on 4 Valium to attempt to consider the Valium at 4: resident went to the from the valied out. Staff not unsteady gait and held the staff also noted the unsteadiness prior to the resident was admunit. The next nursing p.m. and noted the reand down the hall visit and was cooperative. A nursing note dated documented the resident was admunit and was cooperative. A nursing note dated documented the residesk at 10:40 a.m. and reported he/she was atto jump the fence to go thought he/she broke. The nurse assessed to sent the resident to the the hospital. The note returned to the facility reported to the staff the in his/her right wrist. Interview on 6-5-12 at staff A revealed he/she resident #3 attempted said resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the patio whenever he resident #3 did not need to the staff the pations the pations to the staff the pations the pations the pations to the staff the pations the pations the pations to the staff the pations to the staff the pations th	acility more and looked for the nurse obtained a 1-25-12 for one milligram of salm the resident. The staff 40 p.m. and at 5:10 p.m. the ront door opened it and ed the resident had an don to the walls for support. The resident had displayed receiving the Valium. -12 at 8:50 a.m. revealed itted to a behavioral health gonote was 5/10/12 at 7:00 sident had ambulated up ting with other residents, with staff. 5-1-12 at 4:00 p.m. dent went to the nursing downs crying. The resident on the back patio and tried the to music lessons and his/her arm and shoulder. The resident at the continued that the resident went to that the resident at the continued that the resident	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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F 323	checked on the reside minutes or so. The s looked out on the patt to the dining room or the direct care staff a was out on the patio, assigned to supervise plans for the direct caback of the door to east far A said he/she we changes to resident # on the patio. Interview with direct of p.m. revealed resider sometimes said thing said he/she was in the when resident #3 can he/she had hurt him/fence to get to the but the resident also told was hurt before going telling Licensed Staff Interview with License p.m. revealed he/she resident #3 for safety was having more deliarestless. Staff D expi was a highway so cloud interview with License p.m. revealed the pat considered a safe are resident #3's incident as a place residents supervision, except for the direct of the pations of t	ents on the patio every thirty taff said everyone just io when they went by to go kitchen area. Staff A said lso told each other someone however no staff were enter staff were kept on the ach resident's bathroom. as not aware of any tare staff B on 6-5-12 at 3:00 at #3 was "just out there" and is that were not true. Staff B erae a of the patio door the in on 5-11-12 and said the erself when climbing the is load of kids. Staff B said a resident's visitor he/she gon to the nurses desk and in the behalt of the pation on reasons because he/she usions and was more ressed concern that there is et o the facility.	F	323			

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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p.m. revealed the resion 5-11-12 and report the fence to get to his	ident did present to the desk t he/she had tried to jump /her music lessons and						
1:26 p.m. revealed re wanderguard but he/s E said the residents v out onto the patio bed Staff E said at the tim no staff on the outdoo sure what happened. told different staff that lessons, he/she was g	sident #3 had a she was not sure why. Staff with a wanderguard could go cause the area was fenced. e of the incident there were or patio, so no one was really Staff E said the resident t he/she was going to music going to get a bus load of						
1:45 p.m. revealed the related to wandergual staff E revealed he/sh resident at risk in the displayed an increase hallucinations, Staff E returned to the facility occurred. Staff E said behavioral health unit and hallucinations, he resident Staff E said e visited with other resident peared calm, the rehim/herself.	e facility lacked a policy rds. Further interview with he would not consider the courtyard when he/she in delusions and is said the resident had just the day before the accident did the resident had gone to a for treatment of delusions owever upon return of the even though the resident dents and staff and esident just didn't seem like						
	COMMUNITY CARE CE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page go out. Interview with License p.m. revealed the resion 5-11-12 and report the fence to get to his he/she had broken his literview with Adminis 1:26 p.m. revealed re wanderguard but he/s E said the residents vout onto the patio bed Staff E said at the tim no staff on the outdoo sure what happened. told different staff that lessons, he/she was kids, and he/she was linterview with Adminis 1:45 p.m. revealed the related to wanderguar staff E revealed he/sh resident at risk in the displayed an increase hallucinations, Staff E returned to the facility occurred. Staff E said e visited with other resident Staff E said e visited with other resident peared calm, the resident Staff E said e visited with other resident peared calm, the resident him/herself.	OVIDER OR SUPPLIER **COMMUNITY CARE CENTER** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 go out. Interview with Licensed Staff D on 6-5-12 at 2:45 p.m. revealed the resident did present to the desk on 5-11-12 and report he/she had tried to jump the fence to get to his/her music lessons and he/she had broken his/her arm. Interview with Administrative Staff E on 6-5-12 at 1:26 p.m. revealed resident #3 had a wanderguard but he/she was not sure why. Staff E said the residents with a wanderguard could go out onto the patio because the area was fenced. Staff E said at the time of the incident there were no staff on the outdoor patio, so no one was really sure what happened. Staff E said the resident told different staff that he/she was going to music lessons, he/she was going to get a bus load of kids, and he/she was going to get his/her car. Interview with Administrative Staff E on 6-5-12 at 1:45 p.m. revealed the facility lacked a policy related to wanderguards. Further interview with staff E revealed he/she would not consider the resident at risk in the courtyard when he/she displayed an increase in delusions and hallucinations, Staff E said the resident had just returned to the facility the day before the accident occurred. Staff E said the resident had gone to a behavioral health unit for treatment of delusions and hallucinations, however upon return of the resident Staff E said even though the resident visited with other residents and staff and appeared calm, the resident just didn't seem like	OVIDER OR SUPPLIER COMMUNITY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 go out. 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Staff E said the resident had just returned to the facility the day before the accident occurred. Staff E said even though the resident visited with other residents and staff and appeared calm, the resident just didn't seem like him/herself.	OVIDER OR SUPPLIER COMMUNITY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 go out. Interview with Licensed Staff D on 6-5-12 at 2:45 p.m. revealed the resident did present to the desk on 5-11-12 and report he/she had tried to jump the fence to get to his/her arm. Interview with Administrative Staff E on 6-5-12 at 1:26 p.m. revealed resident #3 had a wanderguard but he/she was not sure why. Staff E said the residents with a wanderguard could go out onto the patio because the area was fenced. Staff E said at the time of the incident there were no staff on the outdoor patio, so no one was really sure what happened. 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Interview with Licensed Staff D on 6-5-12 at 1:29 p.m. revealed the resident 43 had a wanderguard but hel/she was not sure why. Staff E said the resident staff that he/she was going to get a bus load of kids, and he/she was going to get a bus load of kids, and he/she was going to get his/her car. Interview with Administrative Staff E on 6-5-12 at 1:45 p.m. revealed the facility lacked a policy related to wanderguards. Further interview with staff E revealed the facility lacked a policy related to wanderguards. Further interview with staff E revealed he/she was going to get a bus load of kids, and he/she was going to get a bus load of kids, a	OVIDER OR SUPPLIER 17E630 STREET ADDRESS, CITY, STATE, ZIP CODE 212 N STH AVE SUMMARY STATEMENT OF DEFICIENCES BURNARY STATEMENT OF DURING STATEMENT OF DURING STATEMENT OF DURING STATEMENT OF DUR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 323	resident in the emerge fall happened but it we resident had a "psych go over the fence at said he/she was of the occurred as a result of the resident did not he that would cause as said the resident sus and a humeral head. Policies related to the monitoring of resider and criteria for resider and criteria for resider unsupervised were restaff E on 6-5-12 at said he/she found not the facility failed to be resident staff had ided delusions and halluct wandering. The resident distal radius and attempting to jump than event he/she perconsident had a BIMS Status) of 2, indicating impairment. The MD inattention that came severity. The resident disorganized thinking severity of the disorgidentified the resident said he resident field the resident disorganized thinking severity of the disorgidentified the resident	e/she did not see the gency department when this yas his/her understanding the notic break" and attempted to the facility and fell. Staff Fine understanding the fracture of the fall. Staff Fine confirmed have any disease process pontaneous fracture. Staff Finance a distal radius fracture fracture. The use of wanderguards and hats wearing wanderguards ents to go on the pation equested from Administrative 1:45 p.m. Staff E looked, but to policy for either. The surrough the pation of a contified with increased fracture of humeral head while he fence of the pation to get to be detected, but was not real. The third staff is detected the distalled the resident had and went, with changes in	F	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 323	behavioral symptoms with the resident's car significant risk for phy identified the resident assistance of two per of Daily Living) excep hygiene which require one person. The MDS unsteadiness and the human assistance for standing position, wal moving on and off the surface-to-surface trathe resident was frequently the MDS identified the disorder and mild occur showed the resident with no injury. Review of the quarter revealed the resident cognitive impairment, and disorganized thin the admission assess continued to have half the MDS noted an infor ADL's. The MDS required extensive as bed mobility, transfers corridor, dressing, toil and was totally deper on and off the unit an for eating. The Cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identifical Alzheimer's Dementical significant in the cognitive CAA (Codated 12-9-11 identificant in the cognitive cognities cognities cognitive cognitive cognitie	that significantly interfered re and put others at resical injury. The MDS required extensive sons for all ADL's (Activities t eating, and personal ed extensive assistance of sidentified the resident with inability to stabilize without moving from a seated to king, turning around, toilet and insfers. The MDS identified uently incontinent of urine, he resident with an anxiety asional pain. The MDS had a fall since admission By MDS dated 3-21-12 with a BIMS of 0, or severe The resident's inattention king remained the same as ment. The resident lucinations and delusions, creased need for assistance identified the resident sistance of 2 persons for so, walking in room and let use, personal hygiene ident on staff for locomotion did required limited assist of 1	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL _DING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	past at times through The Fall CAA dated 1 resident with a history poor balance, unstead crisscrossing steps at cognitive loss and half the facility last review 3-27-12. Care plan in prevention of falls including the bearing assists to provide weight bear ambulation with a gair 2 hand held assist as better that way, anticit resident does not use visual checks for safe his/her room. Addition on 4-23-12, lock wheel of the use of a body a wheelchair, body alar check to ensure it is in leaving the room, and educate staff on menticilet per schedule and out of his/her chair, do to the complete of the nurse Assistant F care plan for the nurse the resident had a toil on when in his/her room, make sure non make sure non the complete of the sure it is in working room, make sure non the complete of the sure it is in working room, make sure non the complete of the sure it is in working room, make sure non the complete of the sure it is in working room, make sure non the complete of the sure it is in working room, make sure non the complete of the sure it is in working room, make sure non the complete of the sure it is in working room, make sure non the complete of the sure in the sure in the complete of the sure in the sur	porientation and lived in the hallucinations and delusion. 2-9-11 identified the of falls, poor coordination, dy gait, awkward times, incontinent, lucinations/delusions. Wed the care plan on atterventions related to luded: 1-2 staff to provide ance for transfers, 1-2 staff ring assistance for the belt and walker at times or sometimes he/she does pate resident's needs, call light, make frequent ty, do not close the door to ms to the care plan included: elchair brakes and initiation alarm when up in the mon when in room alone, in working order before addition on 4-25-12 to dal status, assist resident to define the door to make it he/she needs to addition and ask if he/she needs to addition and and and and and and and and and an	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	4:40 p.m. identified signor between the per notes identified the real 1.5 cm (centimeter) la lip and a less than ½ the right forearm, whi facility. Review of the revisions related to the Interview with Admini 10:23 a.m. revealed to out of the recliner in high wheelchair was next resident fell between E confirmed the lack of the fall and identificand prevent further fall with the staff living room floor on high investigation date resident attempted to fell. The investigation L identified the wheel Interview with Admini 10:40 a.m. revealed the resident's entire wheel plan revealed staff in alarm after the fall.	g notes dated 4-19-12 at taff found the resident on the dals of the wheelchair. The esident had an approximate accration to the right upper cm skin tear to the back of ch staff treated at the care plan found no his fall. Strative Staff E on 6-6-12 at the resident was getting up his/her room and the to the recliner and the the wheelchair pedals. Staff of any investigation of cause cation of interventions to try halls of this nature. 4-23-12 at 6:15 p.m. Found the resident on the is/her back. Review of the data data without assist and also noted Direct Care Staff chair brakes were weak. Strative Staff E on 6-6-12 at they did replace the elichair. Review of the care strated the use of a body	F	323	DEFICIENCY)		
	p.m. revealed the res dining room. Two nu have witnessed the fa	tes dated 5-5-12 at 1:30 ident fell at 12:20 p.m. in the rse aides were noted to all and attempted to reach e/she fell, but could not. The idid sound when the					

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F 323	the emergency depar received 7 stitches to his/her eye. Review of staff made no revision prevent further falls of Administrative Staff Erevealed the resident at the table alone. Staff the resident at the table alone. Staff the resident at the closer and could superclosely. Review of the nursing 6:05 p.m. revealed staff floor next to the reclin p.m. The staff assess abrasion to his/her rigifall investigation date found the resident lyin and the window wall. body alarm in place a fall. Interview on 6-6-Licensed Staff C revealarm even in the resident the fall. Staff C said leducated the direct cacheck the alarm at shafunctioned properly a functioning at the time. Nursing notes on 5-20 the housekeeper healiving room and summ Staff found the resided The alarm was sound.	right eye and was taken to treent. The resident close the laceration above of the care plan revealed in related to attempts to f this nature. Interview with a on 6-6-12 at 10:42 am. was no longer allowed to sit aff E said otherwise the staff e bar where the staff were ervise the resident more. In notes dated 5-25-12 at aff found the resident on the iter in his/her room at 5:05 sed the resident with a small pht shoulder. Review of the discovered the staff ing between his/her recliner. Staff noted the lack of a tithe time of the resident's room at the time of ine/she immediately are staff that they must ift change to ensure it.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER: `		JLTIPLE DING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	wheelchair. The reshis/her left shoulder emergency department to treatment. Intervion 6-6-12 at 10:38 a brought the resident breakfast and he/she wheelchair. Staff E woke the resident eato the living room waitin he/she had instructeresident if still sleepi staff had not revised intervention as of the livery with Admir 10:53 a.m. revealed investigations did not environmental factor cause of the fall, or in prevent similar falls. Observation on 6-6-Direct Care Staff Had assisted the resident to the distaff sat the resident to the distaff sat the resident bar. No one else sa Administrative Staff confirmed the staff was bar for closer supervaway from staff's imiliar literview with Direct 10:20 a.m. revealed	e resident was under the ident complained of pain to and was sent to the ent, however he/she needed ew with Administrative Staff E.m. revealed the staff had to the living room to wait for e attempted to get out of the said the direct care staff arly and brought the resident d left the resident sitting in an of for breakfast. Staff E said d staff not to wake the ang. Staff E confirmed the the care plan with this e 6-6-12 interview. Inistrative Staff E on 6-6-12 at he/she recognized the fall t include the immediate as possibly related to the interventions to try and 12 at 11:52 a.m. revealed and Direct Care Staff I the with toileting then walked ning room. The direct care at a table across from the that the table. Interview with E on 6-6-12 at 12:00 p.m. Were to sit the resident at the dision and not at the table.	F	323			

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	ROVIDER OR SUPPLIER 7 COMMUNITY CARE CE	NTER		212 N 5TH AVE ANTHONY, K			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EA	PROVIDER'S PLAN OF CORRECTI ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	body alarm on him/he off and the staff cannot he/she falls. Interview with Direct 03:55 p.m. revealed th sleep in later in the maybe the resident jutility fell out of his/her chai "entertain" the resident resident about particuting also try to toilet the line of the more on his more on his more of the resident is more at the resident is more at the resident is more at the resident intervention falls. This resident di	even though staff place a er, it is usually already going ot get to the resident before Care Staff J on 6-6-12 at e staff try to let this resident forning, because staff think ust got tired, fell asleep and ir. Staff J said the staff try to not more by visiting with the ular interests. Staff J said the resident every two hours. Strative Staff E on 6-6-12 at ne/she sees the resident nis/her own, and staff just more about what to do when active and what to do when sleepy to prevent falls. Onsistently identify causal 1's falls, then develop and ons in an effort to prevent d sustain multiple falls with laceration of the forehead	F	323			